ATTACHMENT 1
Sample recipient prior authorization denial or modification letter

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
FAX: 608-266-1096
TTY: 608-261-7798
www.dhfs.state.wi.us

Tommy G. Thompson
Governor

Joe Leean
Secretary

State of Wisconsin

Department of Health and Family Services

March 29, 2000

«RecipName»
«RecipAddressLine1»
«RecipAddressLine2»
«RecipCity», «RecipStateZip»

Notice of appeal rights.
MAID: **«MAID»**
County Social/
Human Service Office:
Appeal Date: **«AppealDate»**

Dear **«RecipSalutation»:**

Certain services must be reviewed and approved by the State of Wisconsin Division of Health Care Financing (DHCF) before payment may be made by the Wisconsin Medicaid program.
This process is called Prior Authorization (PA).

Your provider requested that the following services be approved:
Services listed here.

The prior authorization request, PA No. **«PANumber»**, was reviewed by appropriate DHCF professional consultants, and services have been denied or modified as follows:
Denied Services:
Denied services listed here.

Modified Services:
Modified services listed here.

DHCF's denial or modification of the services requested was made for the following reasons:
Denial/modify codes listed here.

Please contact **«ProviderName»** for more information. Your provider has a copy of the Prior Authorization Request Form and can explain the reasons for the denial/modification.

The regulation(s) that support DHCF's actions to deny or modify your provider's request are included in Wisconsin Administrative Code, HFS 107.03(3)(e).
Specific regulations may be listed here.

You may appeal the DHCF decision in accordance with state and federal law within 45 days. To file an appeal:

1) Call your County Social/Human Services office at the telephone number listed above for an appeal form and/or assistance in completing it, or
2) Write to the Division of Hearings and Appeals at the following address by the 45-day Appeal Date indicated in the caption of this letter:

Division of Hearings and Appeals
Department of Administration
P.O. Box 7875
Madison, WI 53707-7875

The appeal form or letter should include:

- the name, address, phone number
- the Medicaid number of the person for whom the appeal is being made
- the Prior Authorization **«PA Number»**, and
- the reason you think the denial or modification of the PA is in error

REMEMBER: You must mail or deliver your appeal to your county Social/Human Services Office or the Division of Hearings and Appeals so it is received by the 45-day deadline or by **«AppealDate»**.

You will lose your right to an appeal if your appeal is not received by the county Social/Human Services Office or the Division of Hearings and Appeals by **«AppealDate».**

If you file an appeal:

- The State Division of Health Care Financing will be required to explain, in writing, the reason(s) for the denial or modification of the services your provider requested. This explanation will be mailed to you and your designated representative.
- You or a representative that you choose (friend, relative, attorney, provider, etc.) will have an opportunity to explain your need for the service to a hearing officer. (You may want to ask your county agency if there is free legal help available in your area.)
- The Division of Hearings and Appeals will schedule a hearing to consider your appeal. Hearings are held at your county Social/Human Services Office. Division of Health Care Financing staff may also appear in person or by telephone.
- Based on all the information available, the hearing officer will make a decision on your appeal, notify you of the decision in writing, and advise you of any additional appeal rights.

Whether or not you appeal the decision, the Medicaid program will pay for any services it has approved. After the hearing officer makes a decision, Medicaid will continue to pay for the approved services plus any additional services the hearing officer directs Medicaid to pay.

If you need information about accommodation for a disability or for English language translation, please call (608) 266-3096 (voice) or (608) 264-9853 (TDD) immediately so arrangements may be made. These telephone numbers are at the Division of Hearings and Appeals and are to be used only for the purposes indicated. Staff at those numbers will not be able to provide you with information about your specific case.

Sincerely,

Peggy L. Bartels, Administrator
Division of Health Care Financing

Sincerely,

Richard M. Carr, M.D. Chief Medical Officer
Division of Health Care Financing